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Buckinghamshire Health and Care System Plans

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Agenda

1. Recap strategy and objectives

2. Key priorities for 2017/18

3. Examples of what this will mean for Bucks residents

Our strong record of achievement:

- **Better Healthcare in Bucks** – transformation programme to centralise A&E and emergency services
- **Stroke and Cardiac** - innovative model of care introduced at Wycombe Hospital
- **Redesigned emergency and urgent care** pathways
- **Nationally recognised innovation to transform primary care**
- **System-wide quality improvement** – aligned monitoring and governance, e.g. Looked After Children
- **Over 75s community nursing** – delivering 'upstream' care to prevent admission and shorten length of stay for our older population

Our Buckinghamshire System Plan

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To ensure the people of Buckinghamshire have happy and healthier lives, supported by a sustainable health and care system

To do this, we must work **as a system** to rebalance the health and social care spend by increasing support for living, ageing and staying well, and prevention and early intervention initiatives.

Our main area of transformation for the next two years is to achieve **joined up primary care and community based services**

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Our focus is to…

- **Improve** patient outcomes and experience
- Shift spend on bed-based care into **prevention and care at home**
- **Join up health and care services**, to reduce waste and duplication
- **Deliver cost and productivity improvements** by implementing best practice
- Provide urgent and emergency care in the **right place at the right time**
- **Use technology** for rapid access to advice, care and support

How our plans align:

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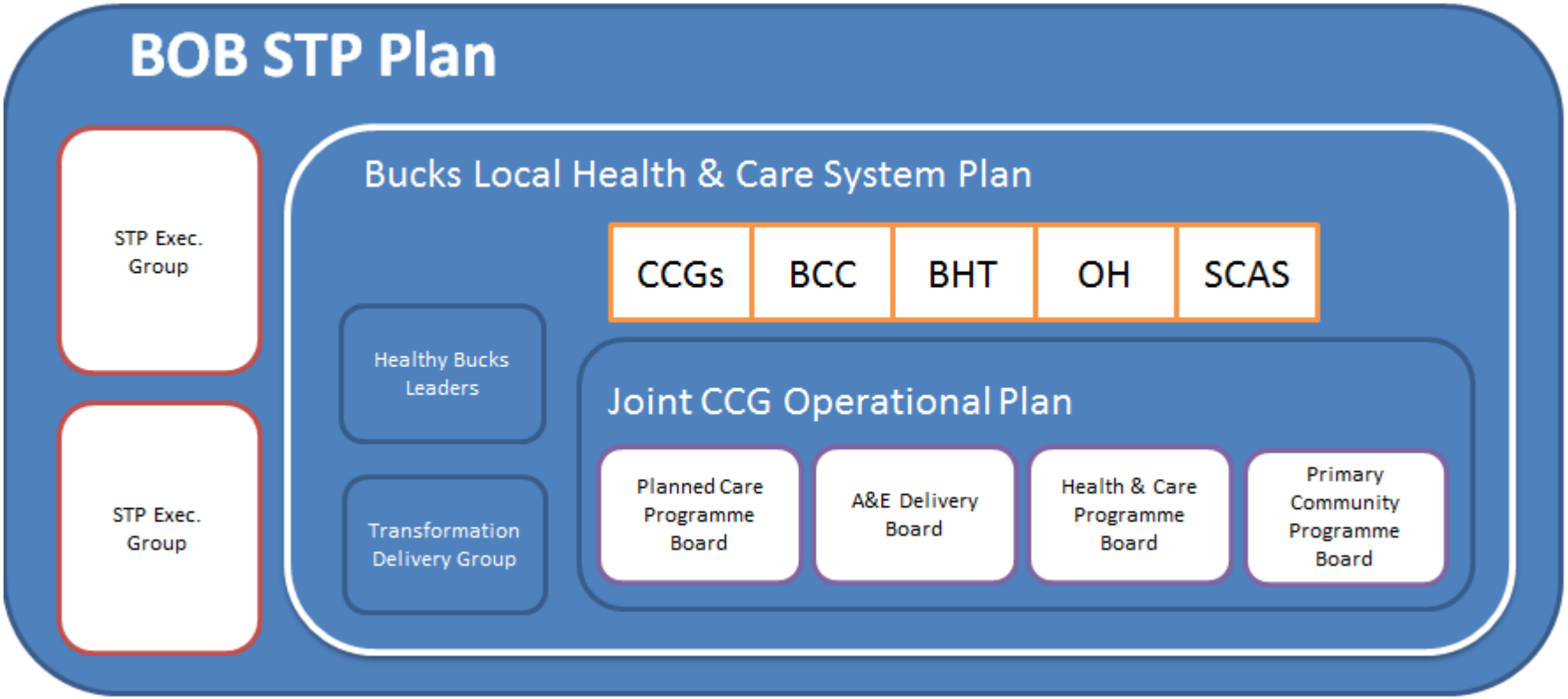

Key: CCGs – Clinical Commissioning Groups, BCC – Buckinghamshire County Council, BHT – Buckinghamshire Healthcare NHS Trust, OH – Oxford Health NHS Foundation Trust, SCAS – South Central Ambulance Service, BOB STP – Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan

Our shared challenges

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An ageing population

A growing population

New demands cost the NHS at least an extra £10bn a year

Evolving healthcare needs, such as the increase in obesity and diabetes

Our strategy:
We need to put care in the best place

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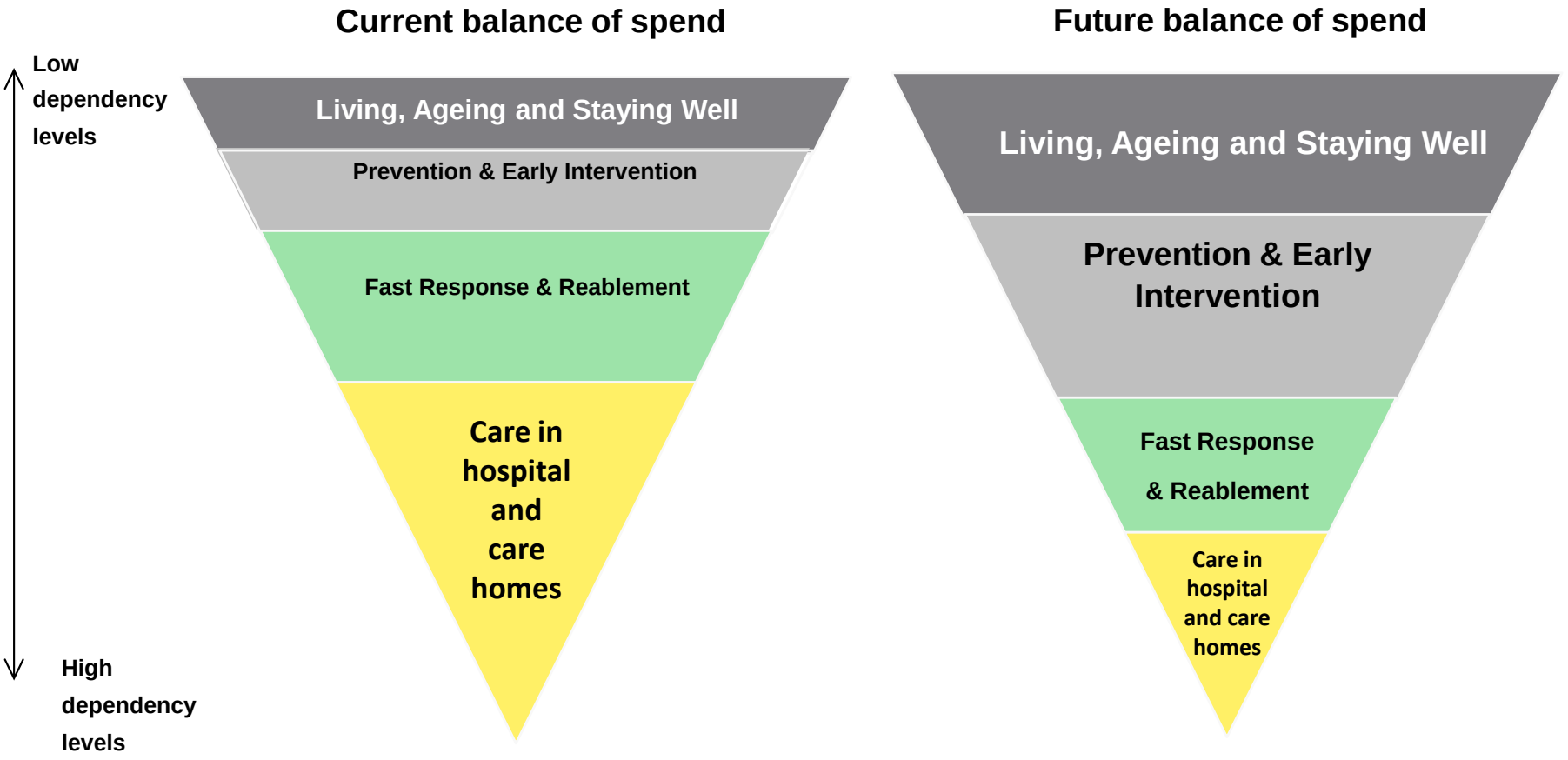
If we do nothing to meet these challenges, our costs will exceed our funding by about £107million over the next four years across the Buckinghamshire health system.



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About **70%** of Buckinghamshire's 'do nothing' gap of £107m over 4 years will come from **local health and care plans**

About **30%** of efficiencies will come from working at scale at STP level

Established programmes of work underway in the Bucks health and social care system

Prevention e.g. obesity

Hospitals sharing back office functions

Workforce, IT systems etc

We have a strong track record in Bucks of improving outcomes & saving money

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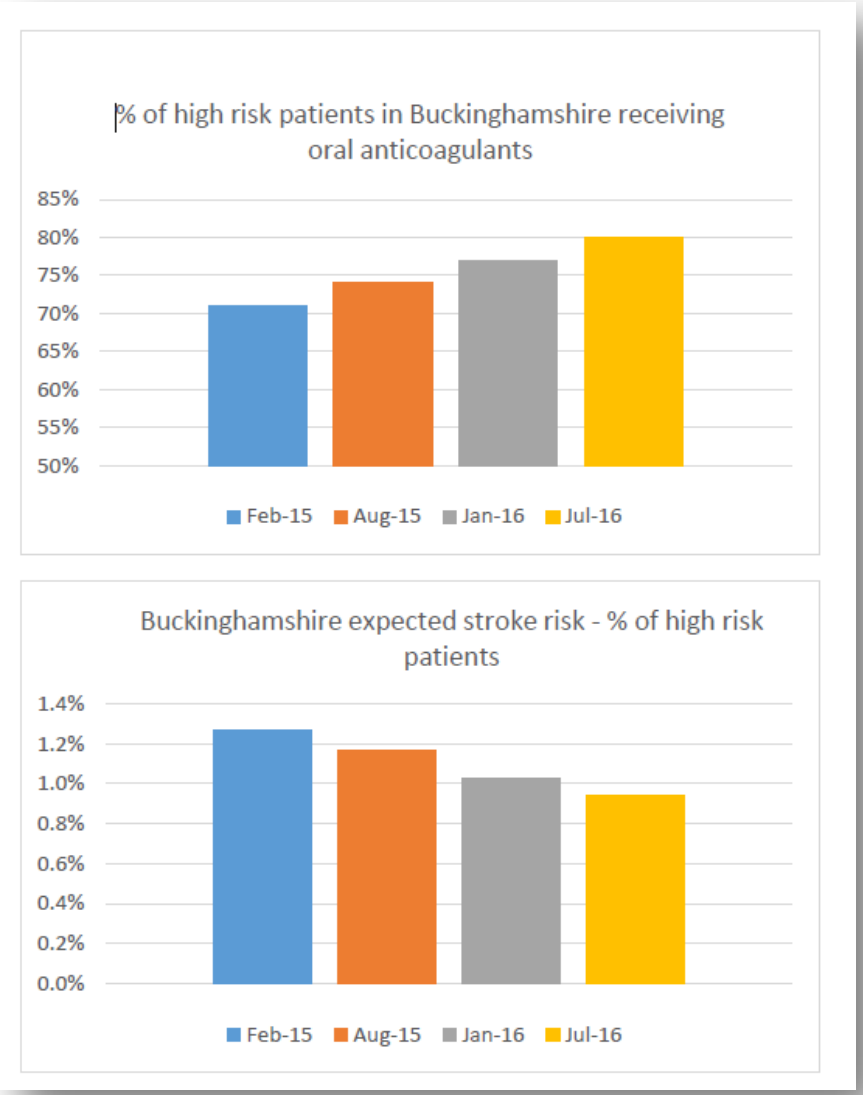
Atrial fibrillation project

(AF = irregular heart rate = much higher risk of stroke)

- Screening means **600 more high risk patients will get medicine** to help prevent blood clots
- **20 fewer strokes every year** (at a care cost of £25,000 per stroke)
- **Net savings of £220,000 a year for the local NHS** (plus long-term care savings)



Plans are based on feedback from public, patients and stakeholders:

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Key priorities 2017/18

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- **Prevention and self-care:** healthy lifestyles and Active Bucks
- **One Bucks Commissioning Team:** further developing joint health and care commissioning across NHS and the Council (adult and children's services, public health, mental health etc)
- **Key providers** are planning a formal alliance to deliver joined up care (FedBucks [GPs] + Oxford Health NHS Trust + Buckinghamshire Healthcare NHS Trust)
- **Continue investing** in rehabilitation and community services, so fewer people need hospital care
- Introducing better, simpler models of care for people with **diabetes and musculoskeletal problems** (back/neck/limb)
- **Stroke and cardiac treatment:** widen catchment, so Bucks patients don't have to travel to London; expanding services to Berkshire
- **Community Hubs:** piloting new ways of joining up health and care closer to home, tailored to the needs of local communities
- **One Public Estate:** six shared projects, using our property assets to provide better services and value to residents
- **Workforce:** increase apprenticeships for support workers, continue reducing agency spend, collaboration on temporary staffing contracts, investment in leadership
- **IT:** development of local digital roadmaps e.g. to share records across organisations

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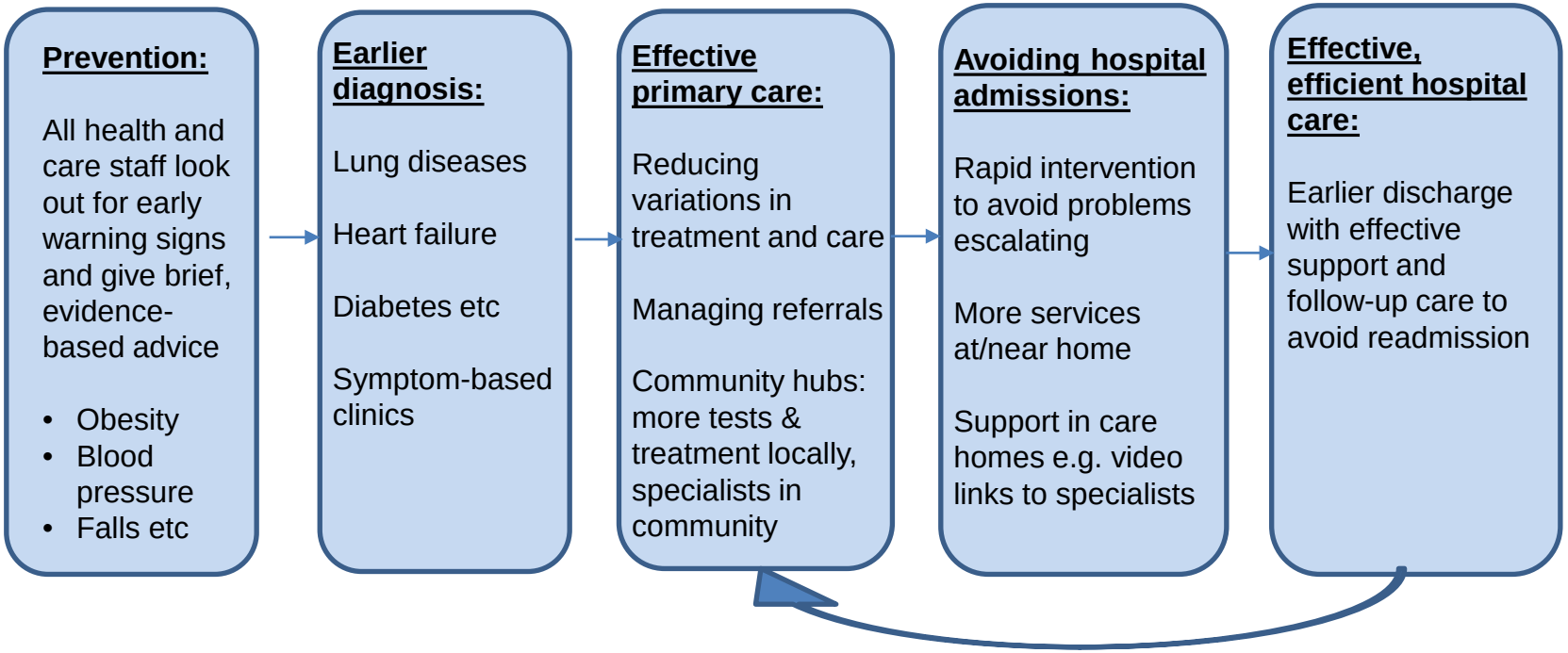
Patient education

Moving care upstream



Reducing the inequality gap

Community Hubs: co-ordinating services & support

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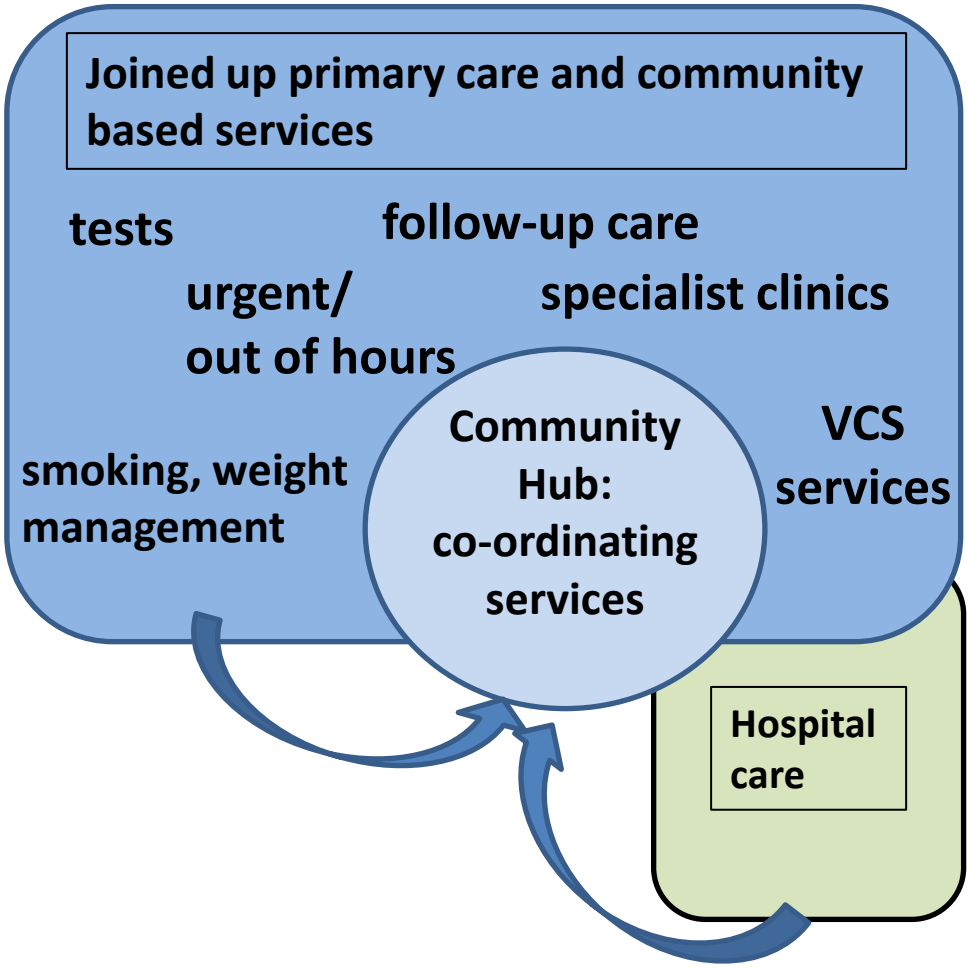
Community hubs will vary (services tailored to local population's needs)

Some services will be in a building, others may be virtual e.g. video outpatients, information and tools

All services co-ordinated across the area, to respond quickly to local patients' needs

Faster, easier access to hospital based specialist advice, through local appointments or video conferencing



A Buckinghamshire Primary & Acute Care System (PACS) in 2018

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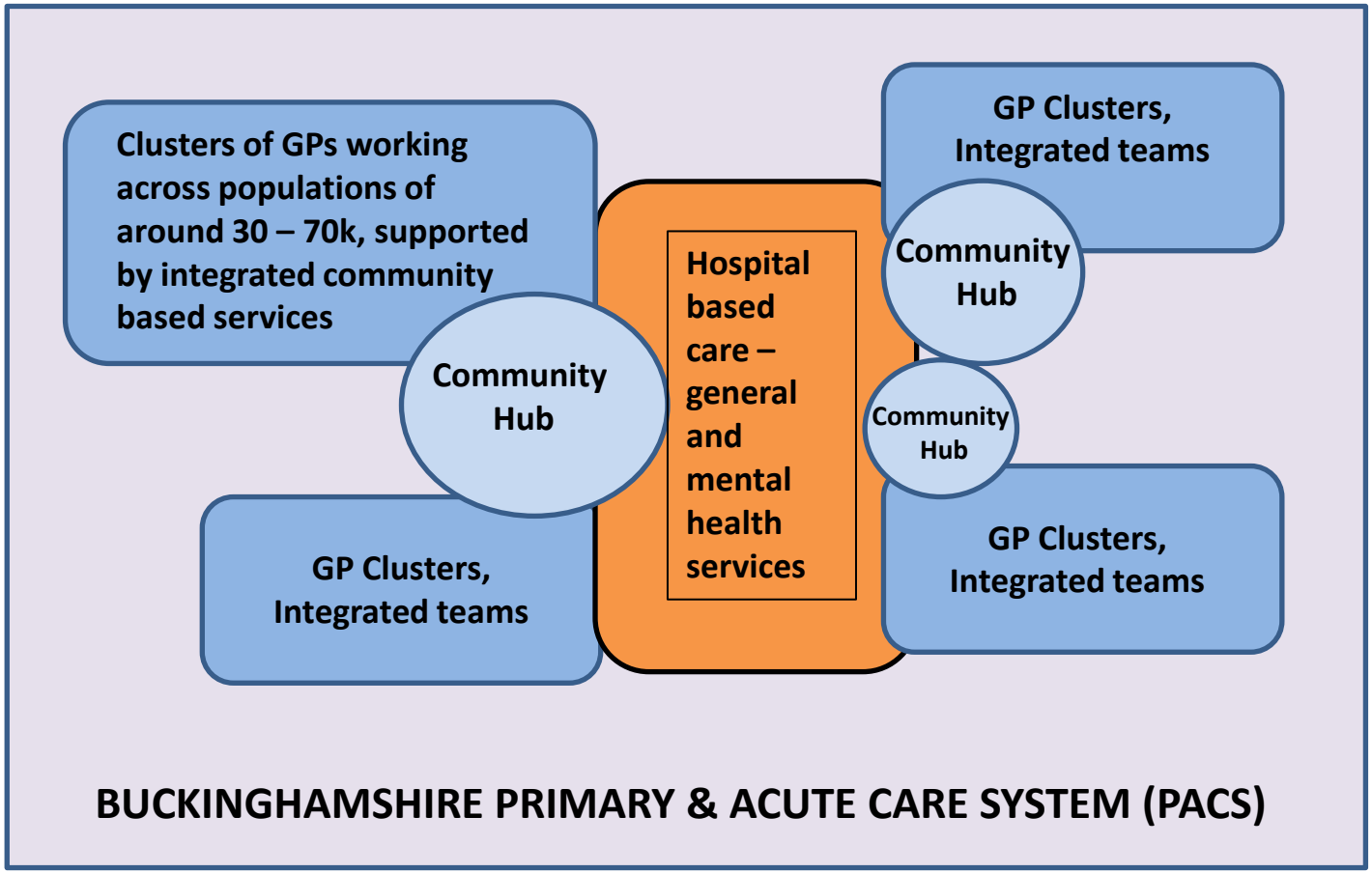
STP: commissioning at scale



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Roadmap across the STP…

Specialist Commissioning: beyond STP boundaries

STP WORKSTREAM: Mental Health (specialist)

STP WORKSTREAM: Prevention

STP WORKSTREAM: Workforce

STP WORKSTREAM: Urgent Care

STP WORKSTREAM: Acute Services Network development

Berkshire West Local Health Economy

Buckinghamshire PACS

Oxfordshire Local Health Economy

STP ENABLER: Local Digital Roadmap for integrated IT systems

STP ENABLER: Estates, Back Office Functions

Case study: Complex health issues

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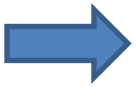
- **Angela, 56, has asthma, diabetes and depression**
- **Lives with daughter Sue, but often home alone as Sue works shifts**

NOW

- Carers visit twice a day, but Angela only allows them to help with food prep and won't discuss her personal care
- Angela and Sue aren't sure who to contact about specific health issues e.g. worsening asthma, pain



They phone 999 for urgent advice and services

Angela has had several unplanned admissions to hospital

This has reduced her mobility

Case study: Complex health issues

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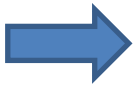
FUTURE

- Angela has a key worker from the **'integrated locality team'** based in the **community hub,** and working with local GP practice
- The team review her care 'package': medicines, equipment and specialist support to help manage her asthma and mental health
- They agree with the local pharmacy to 'blister pack' Angela's medicine to help her take the right dose, and make rescue packs of steroids available
- They also arrange a carer's assessment for Sue



Angela can manage her own health better, and feels more supported

She's less anxious and her pain levels are OK as she's taking her pills; she now allows care workers to help with her personal care

Instead of calling 999, Angela or Sue call her key worker to sort out appropriate support at home or in the local area

Angela makes fewer trips to A&E and doesn't end up in hospital. Sue no longer has to take time off work; she feels better knowing that her Mum can easily get help when she needs it

Case study: Frail older person

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When Ethel's husband Albert died, she thought it would mean giving up and moving into a home.

Ethel has arthritis and breathing difficulties, so Albert had done most of the housework, walked his beloved dog Jack and made sure Ethel took her pills and ate well.

Emma, a nurse, part of the integrated locality team, called in a few days after Albert died:

- Emma made sure Ethel's care needs were assessed and got her some benefits advice and home help
- The team assessed her treatment and made sure they understood what Ethel wanted out of life and how they could all work together to make it happen
- Emma even found a local charity which offered volunteer dog walking services
- **Now every day Ethel has a visitor who takes Jack and Ethel out for a walk, a trip to the shops or just for a cup of tea and a chat**

Case study: Prevention

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Mrs Smith is 75 and has a history of heart failure

NOW

- Multiple admissions to A&E for falls
- Eventually fractures her hip

Long hospital stay

Pressure ulcer

Institutionalised

Loss of confidence

Weakness

Long stay in rehab unit

Needs social care

NHS bill: £50k

Case study: Prevention

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Mrs Jones is 75 and has a history of heart failure

FUTURE

- Aware of her risk of falls and has considered home hazards through local falls campaign
- GP has optimised her medication for heart failure and educated her on falls
- Has been signposted to join local Simply Walks group and Active Bucks exercise class
- Tells friends about falls risks

Happy

Independent

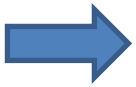
No falls

Case study: Community hubs - referrals

- **Robert, 68, has been referred to see a specialist for a respiratory problem**
- **Lives in Marlow**

NOW

- Travels to Stoke Mandeville Hospital for an appointment
- Has tests and is seen by the consultant



Robert takes his medication, as prescribed by his consultant

Robert takes no other action to improve his health

Robert's condition is managed only up to a point; he makes frequent visits to his GP for additional advice, support and reassurance

Case study: Community hubs - referrals

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FUTURE

- Robert has an appointment at the local **community hub**
- While at the hub, Robert is able to talk to the 'Health Maker' – a volunteer from the local GP practice who has information on a variety of activities that might help him
- She is also able to put him in touch with a local support group

Robert has support as well as a diagnosis and feels well supported

He is seen locally, so avoids unnecessary travel

He makes connections with other people locally who have the same issues as him who are able to provide first hand advice and support

Robert takes control of managing his long term condition and so goes to the GP less often. His disease is better controlled so he is less likely to have a crisis as time goes on.

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Any questions?